US AIR FORCE MEDICAL SERVICE

DIGEST

Winter 1991
Vol. 42, No. 4

Air Force Medicine at Home and Abroad—

Quality Service from the Heart

US AIR FORCE MEDICAL SERVICE

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Distribution: one copy for every four military and civilian personnel in the Medical Service.

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Front cover: (Top) These Medical Service members and many more receive excellent field training at Wilford Hall USAF Medical Center, Lackland AFB, Texas. (Bottom) The cardiac catheterization lab at Wilford Hall offers top-quality care.

Message from the Surgeon General

Air Force Managed Care: The Way of the Future

If I had to sum up the character of our Air Force Medical Service I would do it with one word: commitment. We are committed to some basic standards that require concentrated effort to maintain. Standards such as sustaining an effective, efficient health care management system; supporting the line through a community-based medical program; adequately staffing on-base medical facilities to provide quality family care; and offering compassionate, professional medical service to all active duty military members, their families and retirees.

Living up to these stringent commitments while performing our mission to the best of our ability means keeping a tight rein on resources. It means we need to continue implementing managed care programs at our facilities because our responsibilities are growing and our budgets are shrinking. On the one hand, our patients deserve better access to care; on the other hand we are under pressure from Congress to control our expenses.

In FY90, CHAMPUS costs alone accounted for 45 percent of the medical operations and maintenance bill, a figure that will continue to increase unless we do something about it. We are looking to Air Force managed care to help us meet the diverse demands of a changing Air Force and nation.

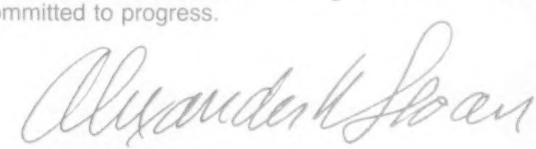
The Air Force Medical Service is not alone in its efforts to manage care. Health care costs in the United States have skyrocketed in the last 20 years, rising from 5 to 12 percent of the GNP. As a result of this increase, more and more of the civilian health community are turning to some form of managed care. In fact, the percentage of the U.S. population enrolled in preferred provider or health maintenance organizations has risen from about 5 percent in 1982 to 40 percent in 1990.

Our own current efforts to bring control of care and resources down to the local level include Alternate Use of CHAMPUS funds from Congress, Management Efficiency programs funded by the Air Force line, sharing agreements with DOD and Veterans Affairs, Health Care Finder and Partnership agreements.

The prototype for future Air Force managed care programs is based on our two Catchment Area Management (CAM) demonstrations, each made up of a wide range of managed care components. We expect to implement CAM-style managed care programs at more than 30 additional sites this fiscal year with new sites following in the next two fiscal years.

What is the basis for our standards of excellence and our desire to control resources by expanding managed care? A commitment to caring. We want our patients to receive the highest quality care at the best price, even when they must go outside the direct care system to find it. Our mission is great and our commitment is strong, as the 17th century sage, Thomas Fuller said, "A good cause and a good tongue: and yet money must carry it." To continue in our success, we must continue to better manage our money.

I know I can count on your proven skills, enthusiasm and dedication to bring Air Force medicine into the world of managed care. After all, we are committed to progress.



ALEXANDER M. SLOAN
Lieutenant General, USAF, MC
Surgeon General

What's in a Name?

The Value of Patient Sensitivity

Lt. Col. Judith Barger, NC

"The patient is the most important person in the hospital. The patient is not dependent upon us, we are dependent upon him. The patient is not an interruption of our work, he is the purpose of it. The patient is not an outsider to our business, he is our business. The patient is a person, and not a statistic. He has feelings, emotions, biases and wants. It is our business to satisfy him."—Credo

The patient entered the clinic and approached the reception desk, paperwork in hand, to complete the necessary appointment. When no one greeted her, and no routine check-in procedure was evident, the patient stood quietly for what seemed to be a long wait. Eventually, the patient was recognized, but she was given unclear instructions that prolonged the time before she could complete the reason for her visit. When she was finally summoned for her appointment she was called by her last name only. "They don't even care who I am," she thought to herself.

The Importance of Self-Concept

What's in a name? For our patients, a lot. Some of us can remember the lines of a poem by Emily Dickinson learned as a child: "I'm Nobody! Who are you? Are you—Nobody—too?" Our names, preceded by our proper titles, give us an identity, a sense of self-concept in an otherwise anonymous society.

People are not born with self-concept; it is learned, primarily through interpersonal relationships with significant others. C. H. Cooley refers to this perception of self as the "looking glass self." That is, "self-concept is a reflection, largely, from the minds of others" (1).

Outside Influence on Self-Concept

How do we view our patients? As valued clients? Our patients look to us, the staff of the medical treatment facility, for a reflected indication of their worth. Our words, actions and attitudes all convey a message.

What message do we convey? Walk with me through a hypothetical outpatient clinic of a busy medical treatment facility:

- Staff complete check-in procedures without ever making eye contact with patients.
- A group of patients is called at once and taken as a group to examination or treatment rooms in the back.
- Patients are sent into examination or treatment rooms with no instructions on how to prepare for the procedures.
- A delay ensues, during which the patients sit, freezing, in a state of undress, and without explanation for the long wait.
- During the wait, patients overhear staff engaged in personal conversations.
- The conversations continue during procedures and exclude the patients.

An Air Force nurse anesthetist at Wilford Hall takes time to share while giving care.

Positive Influence on Personal Identity

How might the messages conveyed above be changed to reflect better sensitivity to patients' identities?

Check-in: A prompt greeting or a timely, "I'll be right with you," and a sincere smile give patients a sense of recognition at the beginning of the clinic visit. Giving necessary instructions in a personalized manner makes the patients' processing easier and turns it into a more pleasant experience for them.

Procedure and Recognition: If the pace of the clinic does not permit calling each patient back to the examination or treatment rooms individually, using correct titles and names and giving clear instructions to each patient by name can help stress individuality. Taking that extra minute to glance at both name and title, and using both when addressing patients, make a world of difference to the patients.

Waiting: If providers are not immediately available, keeping the patients notified of delays can relieve their anxiety and help ease the inconvenience of waiting indefinitely, unclothed in an examination or treatment room. Personal conversations carried on within earshot of patients, especially when they infringe on the patients' scheduled appointment times, do not make the patient feel valued and important.

Conclusion

Combs reminds us that, "A positive view of self is learned, and being learned, it can be taught .... People learn that they are liked, wanted, accepted, and persons of dignity and integrity because they have been treated as such" (2). Let's carefully consider what we, the staff of medical treatment facilities, are teaching our patients about their worth, and let's determine to project positive images for them to reflect.

Dental patients at Wilford Hall appreciate the personal, professional attention they receive.

Lt. Col. Judith Barger is a staff nurse at Wilford Hall USAF Medical Center, Lackland AFB, Texas.

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1. Hamacheck DE. Encounters with Self. Holt, Rinehart & Winston 1971; 48.
2. Combs AW et al. Helping Relationships. Allyn & Bacon 1972; 148.

Testimonial to Compassionate Care in the Air Force

Dorothy C. Milam

(Editor's note: The following is an excerpt of an article written by Ms. Milam for the San Antonio Cancer Therapy and Research Center and forwarded to the Air Force surgeon general.)

All of a sudden, an unscheduled abrupt halt disturbed the routine cadence of my life. The pronouncement that I was the one in ten to be diagnosed with breast cancer certainly does deserve high marks for getting one's attention. It has fundamentally and profoundly rearranged the way I perceive my life, and very quickly forced a healthy shift of my priorities.

In early November 1989, on a routine mammogram, my very skillful radiologist, Dr. Veronica

Rouse, identified a suspicious area in the upper outer quadrant of my left breast, and within hours, alerted the surgeons at Wilford Hall USAF Medical Center, Lackland AFB, Texas. The next day I was examined and a needle biopsy was done, which unfortunately proved to be positive. Within two days I was scheduled for surgery.

The rhythm of my existence was about to change dramatically, but I would not permit the framework of my life to collapse. My confrontation with anger was major. I felt a very real contempt for the illness that in silence had struck me—but I also made myself, though grudgingly, respect it for its tremendous potential danger. It was notoriously treacherous—a formidable adversary indeed. I wasn't dealing here with a skin rash. This stuff could take my life. Really? Yes, really! Well excuse me, not today; I was not ready. I planned to be as inhospitable as possible to this renegade invader. I would engage it in guerrilla warfare, and I would win!

My surgery was performed at Wilford Hall USAF Medical Center where I subsequently received the best care available anywhere in the world, civilian or military. My gifted and dedicated Doctors Durk Rodriguez, Jon Getz, Richard Roettger, Rasa Silenas, Robert Thurman, and Doctors Arnold Walder, John Howe III and Bennett M. K. Lau of the civilian medical community, were all wonderful. Their assembled wisdom, collective intelligence and extraordinary skill coupled with their compassion and sensitivity sustained me. I love them all.

They encouraged me to ask hundreds of questions, and I did. I learned very quickly that nothing is irrelevant, and since I had to go through all this mess anyway, I may just as well try to make it a learning experience. Usually, devotion to detail is not a part of my daily life—you bet that changed. I paid undivided attention to every word the doctors said. I cannot stress strongly enough how important the dialogue with your doctors is. They must be approachable; they will be your stabilizing force.

On Nov. 13, 1989, a lumpectomy plus a node dissection was successfully performed and arrangements for follow-up radiation were made, but yet another misadventure occurred. Destiny struck an additional crushing blow—further pathological examination of the tissue revealed microscopic traces of carcinoma on one border of the biopsy, and two nodes were involved. That instantaneously changed the complexion of everything.

Dr. Rodriguez was as disappointed as I was, and he was incredibly kind when he broke the news to me. After much discussion and evaluation before the tumor board, it was the unanimous opinion of the surgeons that it was in the best interest of my long-term survival to consent to a modified radical mastectomy, followed by a six-month chemotherapy protocol.

The tremendous confidence that I had in my doctors made my decision—of course we would proceed. On Jan. 13, 1990, my modified radical mastectomy was performed uneventfully, and only a hairline scar remains. My recovery was complete, rapid and uncomplicated. However, I really agonized over the fact that I had to undergo chemotherapy.

I met Dr. Tom Bradley, my brilliant oncologist, on an extremely positive day, and it has only gotten better. He is a delight and has a strong shoulder on which to lean. I admire his phenomenal patience. He explained every possible systemic side effect of the chemotherapy drugs; sometimes they occur and sometimes they don't—no two people react to some drugs in the same way. There is no insulation. You have to hear and know about all the risk factors.

There are no sure cures, no guarantees, no short-term remedies and no easy outs. Disillusioning? You bet. This is not just another nuisance value decision. There were no two ways about it. I had super gut reservations. I knew the ramifications of my decision would affect the quality of the rest of my life. By this time, so much information, dense with medical terms, was crammed into my brain, that even though I knew there were no redeeming virtues in it, I gave some serious thought to dissolving into hysteria—but having a nervous breakdown takes time, something I had none of to waste. So I decided against that and managed, with much trepidation, to muster enough discipline to volunteer for the Southwest Oncology Protocol Research Project, and I was accepted as a perfect candidate.

The prevailing, dominant and advance thinking is overwhelmingly in favor of chemotherapy's being highly beneficial, but nobody said I had to like it. So I appeared the morning of my first treatment with less than zestful enthusiasm, a poorly disguised

optimist. I wanted the positive effects of the powerful drugs to be immediate, substantial and tangible; of course, they were not.

It's a long, scary process, and I was just beginning. As I understand it, the chemotherapy drugs are a "positive poison" (certainly a contradiction in terms) because they aggressively attack and kill the free-wheeling cancer cells, but in the process they also do extensive damage to healthy organs—to say nothing of the devastation they visit upon the immune system. All these are supercharged conditions to live with 24 hours a day. It's no wonder you are constantly and critically observed.

The mega-stress to which your body and mind is subjected during chemotherapy is very complex. You are never sure how the drugs will affect you or when. Some have delayed reactions; nothing is routine.

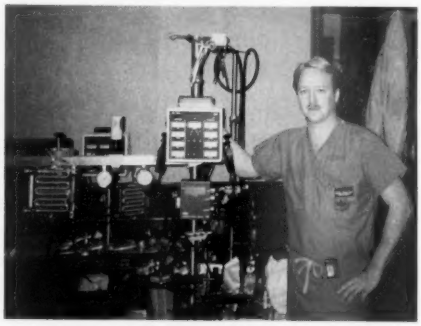
My talking sessions with Dr. Charles Bowden saved my sanity more than once. He led me through the tough realities, and I am extremely grateful for his kindness and counsel. Now that I have passed over the ominous times, I must tell you I would really much rather not have gone through this adventure.

There *is* light at the end of the tunnel. Dr. Rasa Silenas and Dr. Robert Thurman, my reconstruction surgeons, have begun the tedious and infinitely precise, meticulous process of rebuilding my body so it will be normal again. It's incredible to watch them. They are much like architects and artists, drawing, marking and measuring. It's unbelievable to see the remarkable results of their brilliance in this highly specialized field of surgery. The quiet power of their skill and brains is truly inspiring. How fortunate I feel to have these physicians in my life and on my side—I can't lose, nor can I ever express the depth of my gratitude to them.

I know the medical profession will cautiously only use the term *in remission* when it comes to carcinoma, but in my case I choose the word *cured* because I know I am—and the spill of time will prove me correct.

FASTER THAN EVER. SrA. Lilibeth G. Capati of the Epidemiologic Research Division at Brooks AFB, Texas, performs diagnostic tests in the recently upgraded Armstrong Laboratory. The epidemiology division, experts in epidemiology, preventive medicine and disease surveillance, provides reference laboratory services to medical treatment facilities (MTFs) worldwide, performing more than 1.1 million tests annually. After surveying 120 MTFs in 1985, the division found that about 265,000 tests were being referred to commercial labs annually at a cost of about $4.1 million. To reduce costs by increasing their own efficiency, the division developed an automation project and tested it at 30 sites. They obtained software for the project through cooperation with the Department of Veterans Affairs, saving thousands of dollars. Using automation, specimen turnaround times decreased from 14-21 days to three days, and savings for the year was $2,279,483. Plans are now underway to expand the upgraded services to 90 MTFs by the end of FY92.

Capt. Daniel R. Zayac



Capt. Daniel R. Zayac literally takes 300-350 lives into his own hands each year. He is a cardiovascular perfusionist at Wilford Hall USAF Medical Center, Lackland AFB, Texas, operating the heart/lung equipment during open heart surgery. After 11 years in the Air Force, this diversely skilled captain has found his niche.

Zayac joined the Air Force in 1980 without a job reservation. "I could have been a cop, a cook, a couple of other things or a medic," he said, "and I picked medic." He began his Air Force career as a medical service specialist, training at Sheppard AFB, Texas, and then working as an emergency medical technician in the emergency room at the 416th Strategic Hospital, Griffiss AFB, N.Y. In 1984, Zayac returned to Sheppard AFB and attended the Physician Assistant (PA) course. He did an internship at the Air University Regional Hospital, Maxwell AFB, Ala., and later worked as a family practice PA at the 380th Strategic Hospital, Plattsburgh AFB, N.Y.

"By far and away, I like what I am doing now the most," said Zayac of his current position. "I like clinical medicine, I like dealing with people, but I prefer the operating room setting." Zayac was selected in 1989 to attend perfusion school at Harper Grace Hospital in Detroit, Mich. He spent six months there for didactic training and performed his six-month clinical rotation at the Brooke Army Medical Center, Ft. Sam Houston, Texas. In January 1990, Zayac began work at Wilford Hall as a staff perfusionist.

Zayac finds being a cardiovascular perfusionist exciting. "My job involves a tremendous amount of responsibility, and every case has the potential to be quite terrifying," he said. "Although you do the same thing, every single case is different. Little aspects of the job can change at any given moment and you need to be on your toes; you need to be able to think on your feet and act quickly to address situations that may just pop up during the procedure."

Just exactly what is this procedure? A perfusionist runs the machine that acts as a heart and lung for a patient during open heart surgery. On the day of a surgery, Zayac comes to the hospital early to set up for his vital mission. "I get the machines ready, primed with fluid, and check all the safety equipment. I check the circuit itself that will hold the patient's blood," said Zayac. "The preoperative setup of equipment is time-consuming and usually takes a couple of hours."

After the surgery begins and the patient's chest is opened, the surgeon takes the lines from the machine and inserts them into the heart using a cannula, or small tube. One cannula is placed in the right side of the heart into the Inferior Vena Cava (IVC) and the other cannula in the aorta. "What we do," said Zayac, "is take blood from the patient's venous side, the IVC and the right atrium. It comes back through our equipment where we oxygenate it, warm or cool it, and filter it. Then the blood is pumped back into the patient's aorta, bypassing the heart and lungs."

The perfusionist must be careful not to introduce any foreign substances into the patient from the machine, which is a complex circuit of tubes, pumps and cannulas. "The scary part, though, is that when you have everything ready to go, you still do not know whether it is going to keep the patient alive until you commit yourself and initiate the bypass," said Zayac. "The first 30-60 seconds of bypass are kind of exciting because everything happens so fast. You commit yourself—in other words you drain all of the patient's blood into your machine—and if you can't oxygenate the blood or handle it properly, the patient could die."

In addition to running the heart/lung machine, Zayac operates blood salvage equipment to reduce intraoperative blood loss. "During an operation, blood is salvaged back into our machine where it is spun down and concentrated," he said. "Then we wash the red blood cells, and we can give the blood back to the patient." As a perfusionist, he is also responsible for interaortic balloon pumps and ventricular assist devices. "These devices are bridges to recuperation that give rest to the heart or an area of the heart that is still failing after surgery," said Zayac.

Being a perfusionist has taught Zayac a lot about teamwork, an important part of Air Force medicine. "You have to learn to depend on other people implicitly," he said, "and that attitude carries over into all aspects of medical care. Teamwork is a must."

A Unique Mission

Dental Forensic Identification at Dover

MSgt. Joseph H. Smith

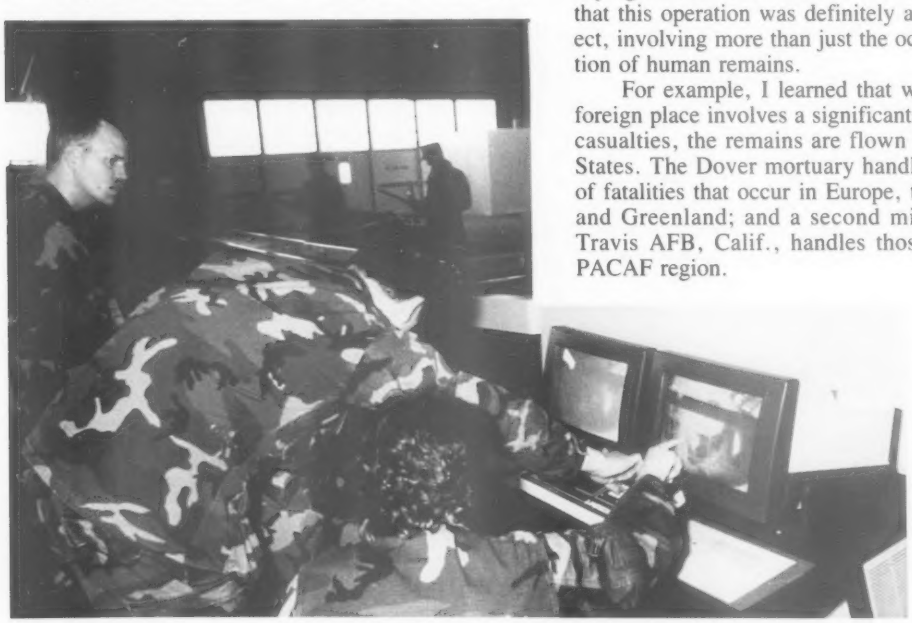
The large plaque in the hall of the 436th Air Base Group Port Mortuary, Dover AFB, Del., caught my eye. In fact, it was the first thing I noticed as it hung there, paying silent tribute to the thousands of men and women who had died and passed through this place. Each of the 35-40 small brass plates on the plaque displayed the name of an event followed by the number of casualties that occurred as a result of the tragedy.

At first, I noticed the magnitude of the numbers: Vietnam—21,693; Guyana—913. As I continued to look at the plaque, names of events triggered memories and quickly reminded me of the fragility of life: Pan Am Flight 103—25; Space Shuttle Challenger—7; but, as I was soon to find out, the journey for these men and women who lost their lives did not end with their tragic deaths. Behind the names and numbers, there is another story.

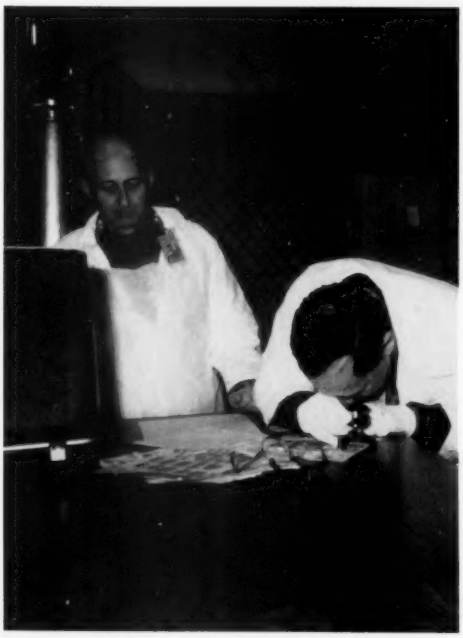
Dover Port Mortuary and AFIP

As the newly appointed superintendent of dental services at Dover AFB, I was very attentive during my indoctrination tour of the port mortuary. My new assignment, as it turned out, was not only the home of the USAF Hospital Dover and the 436th Military Airlift Wing, but also of America's largest military mortuary. I was admittedly a novice when it came to mortuary affairs. I knew that forensic dentistry played an important role in the positive identification of human remains, and I knew that there were standard operating procedures for dental technicians who assisted the dental officer on call with positively identifying an accident victim. I soon found out, though, that this operation was definitely a much bigger project, involving more than just the occasional identification of human remains.

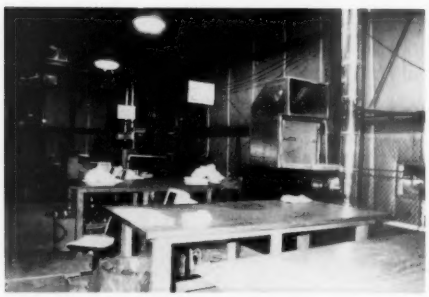
For example, I learned that when a disaster in a foreign place involves a significant number of military casualties, the remains are flown back to the United States. The Dover mortuary handles all mass groups of fatalities that occur in Europe, the Azores, Iceland and Greenland; and a second military mortuary at Travis AFB, Calif., handles those occurring in the PACAF region.



At Dover's port mortuary, wartime casualties are scanned by a fluoroscope to locate any unexploded ordnance.



Comparing fingerprints ***(left)*** *taken at fingerprinting and photography stations* ***(below)*** *with fingerprint cards maintained on some of the victims can result in positive matches. A match is one more step toward positive identification.*



The real responsibility for identifying casualties belongs to the Office of the Armed Forces Medical Examiner, a department of the Armed Forces Institute of Pathology (AFIP) located in Washington, D.C. Upon notification of disasters, people from AFIP mobilize and relocate to do their job, usually to the actual site of the disaster if it occurs within the United States. When disasters occur on foreign ground, involving large numbers of fatalities, AFIP personnel ordinarily relocate to Dover AFB's mortuary, the largest of the two port mortuaries, and process the remains here. Occasionally, depending on the location of the disaster, medical examiner teams will deploy to foreign disaster sites as well. The Office of the Armed Forces Medical Examiner is composed of a staff of pathologists, anthropologists, dentists, photographers and technicians who specialize in forensic identification and postmortem examination.

Chief of forensic dentistry at AFIP, Col. Harvey Kessler manages the dental portion of the identification process. AFIP dental personnel, a maximum of seven dentists, relocate to Dover AFB when the casualties are high, in part because there are no dental assistants assigned to their staff, and the dental assistants at Dover AFB are relied upon to provide important manning support. Occasionally, Dover dentists are called upon to help as well.

As my initial tour of the mortuary ended, I secretly hoped I would not have the opportunity to return anytime soon. Unfortunately, I had a feeling that my on-the-job training in mortuary affairs was about to begin—it was late August 1990 and Iraqi forces had invaded Kuwait just a few weeks earlier.

Desert Storm and Dover

The early days following the invasion of Kuwait were mostly filled with anticipation of a worst-case scenario. Casualties were expected to be high because of the extremely dangerous nature of desert warfare. Because of the expected number of casualties, dramatic changes had to take place at our facility, which could handle, at the most, 100 sets of remains a day. In less than 30 days, a brilliantly orchestrated expansion project developed a design for new construction with completion of construction following 23 days later. We also had to build up our manpower resources. We set up a multi-service operation, combining forces of the Air Force, Army, Navy, Marines and Coast Guard with members always on call.

Although, fortunately, the number of deaths never reached expected proportions, the mortuary received a steady flow of casualties throughout the Persian Gulf War. After arriving from the theater of operations by plane, the remains went through an airport-type scanner (fluoroscope) that checked for unexploded ordnance. Then the remains were transported to the mortuary to begin normal identification processing. A computer kept track of the remains by using a bar-code system to log the remains in and out of all the processing stations.

Remains Processing at Dover

Wartime casualties are processed through the fluoroscope and then continue with normal non-battle procedure as follows: In the mortuary building, at the

first station for identification processing, personal effects and clothing are removed and photographs are taken to show the condition of the body upon arrival at the mortuary. The second step is the FBI station and fingerprinting, followed by full-body medical radiographs, or X-rays.

The dental stations are next. Dental forensic identification is very reliable, especially when no other methods are available because of massive trauma. At the dental station, a series of full-mouth radiographs are taken and developed, followed by a full-mouth charting of the dental status by the dental officer. Later these charts and radiographs will be compared to the "believed-to-be" identity of the body.*

After the dental identification is complete, the bodies are sent to the medical examiners for further medical evaluation. Finally, the bodies reach the embalming and cosmetology area where they are prepared for viewing by the family. Some of the remains are so severely damaged that they cannot be adequately prepared to allow viewing. However, the majority are prepared and can be viewed, and each of the viewable deceased service members are dressed in full service dress uniform, complete with all of their awards and decorations.

Coping with Work at Dover

Working at the mortuary is a unique experience that stirs up a variety of emotions. Some of the more seasoned veterans seem to take the job in stride. SSgt. Howard Huber, a dental technician, is so experienced and works so confidently that he is often mistaken for one of the medical examiners when working with the remains. Other technicians do not handle the experience as easily. Many dental assistants volunteering to work at the mortuary for the first time find they cannot cope with the flood of emotions they experience; they may need to leave the mortuary grounds for a short time to regain their composure.

Our dental staff, though, treats working in the mortuary as a special duty assignment that the Dover dental clinic has been entrusted with. They take great pride in knowing how important the identification process is to the family members of the deceased, and they approach the process with professionalism and understanding.

Conclusion

Throughout my learning experience at Dover, it has become clear to me that the United States, more than any other country in the world, dedicates a great deal of time and energy to ensure that its fallen comrades are properly identified and returned to their families honorably and quickly. News reports shortly after the cease-fire during Desert Storm shocked Americans when they spoke of mass graves of thousands of Iraqi soldiers, left for others to sort out later. But in our country, the military who lose their lives are not simply forgotten; they are returned to the next of kin with dignity, honor and pride.

On my last visit to the port mortuary, I noticed that a new brass plate had been added to the plaque in the hallway that reads: Desert Shield/Desert Storm—310.

*The Newfoundland-Gander airplane crash in December 1985 brought about major changes in the military's preparation for dental identification. All 248 who perished in the crash were flying with their dental records. This made the comparison of before-death (ante mortem) records with after-death (postmortem) remains nearly impossible. As a result of this disaster, all military members are required to have a duplicate panograph X-ray on file at the DOD panograph repository, and all dental records are mailed to the next duty station.

MSgt. Joseph H. Smith is the superintendent of dental services at the USAF Hospital Dover, Dover AFB, Del.

Duplicate panograph X-rays, taken of all military members and stored at the DOD repository in Monterey, Calif., prove invaluable in positive identification.

Malcolm C. Grow and the Alaskan Flight

George M. Watson Jr., Ph.D.

Before Maj. Gen. (Dr.) Malcolm C. Grow became the first surgeon general of the U.S. Air Force, he was already well-known for his medical activities. Grow was a recognized leader in creating unique equipment, such as armored vests and electric gloves, to help the flyers during World War II. He was most influential in the establishment of an independent Air Force Medical Service in 1949. His efforts to gain autonomy for Air Force medicine were not all made at once, however. Grow participated in many enterprises during his career, ever widening his circle of influence and friends.

One of Grow's early experiences as a major in the Army Air Corps enabled him to earn the respect and friendship of Gen. Henry H. "Hap" Arnold, commanding general of the Army Air Forces during World War II and the Air Force's only five star general. As a lieutenant colonel, Arnold led the Army Air Corps Alaskan Flight with Grow as his flight surgeon.

Overview of the Alaskan Flight

In the summer of 1934, the Army Air Corps staged the much-heralded Alaskan Flight with 10 of its most modern bombers: twin-engine, all-metal Martin B-10s with enclosed cabins, a ceiling of 28,000 feet and a speed of more than 200 miles per hour. The mission, led by Lt. Col. Arnold, covered 8,290 miles round-trip from Bolling Field in Washington, D.C., to Fairbanks, Alaska. The crews numbered 14 officers and 16 enlisted airmen, and their assignment was threefold: to prove the feasibility of deploying air forces to Alaska in time of need; to photograph landing sites suited to frontier defense; and to test the possibilities of rapid and large-scale photomapping of terrain (1).

Formed into three flights, the B-10s left Washington, D.C., at 11:30 a.m. on July 19, 1934. In six days of flying, the bombers averaged 157 miles per hour and covered more than 4,000 miles. They put down along the way at seven selected cities. First, in the United States, they stopped at Dayton, Ohio, and Minneapolis, Minn. Then, in Canada, they put down in Winnipeg, Manitoba; Regina, Saskatchewan; Edmonton, Alberta; Prince George, British Columbia; and White Horse in the Yukon Territory. They

Top: *Picturesque Chilkoot Barracks was the first Army post established in Alaska.* ***Middle:*** *Despite being submerged in salt water for more than 12 hours, this plane was returned to flying condition by B-10 mechanics.* ***Bottom:*** *The B-10s line up at Bolling Field in Washington, D.C., before flying to Alaska. (U.S. Army Air Corps photos)*

reached Fairbanks, Alaska, on July 24 just before noon (1).

Results of the Flight

After the Army's disastrous performance in flying U.S. airmail routes earlier that year, the Alaskan Flight gave American military airmen much-needed confidence and publicity. The Air Corps had lost 12 pilots and 50 aircraft on the mail runs that spring. Now some of its leading members showed that Air Corps pilots could navigate over long distances. The trip allayed congressional suspicions that the Air Corps could not deliver bombs if it could not transport mailbags.

Also, the accomplishment of the B-10s emphasized the need for modern equipment and suitable instruments to operate aircraft, something American airmen generally lacked in those years of lean funding. For Arnold, who had been in charge of the Western zones of responsibility during the airmail misadventure, the success of the Alaskan Flight was a personal vindication and triumph (2, 3).

Record of the Flight

During the Alaskan Flight, Grow kept a personal diary where he recorded flight times and banquets and festivities held for the crew. He was very blunt about the nature and quality of the ceremonies—whether he liked them or not, he said so. In Alaska, Grow observed the beauty of the land and often mentioned its teeming wildlife, moose, deer, bear and all types of fish. Grow also noted the rainy and foggy weather conditions that frequently grounded the crews, keeping them from performing their photographic missions. He described his medical treatment of several crewmen suffering from minor infections and injuries.

Perhaps Grow's most notable recollection was of the time when one of the B-10 bombers crash-landed in an Alaskan inlet. He was impressed with the manner in which two crew members engaged the local population to help secure the aircraft and eventually wrench it back from 45 feet of water.

Grow's diary was the only known diary among the crewmen, and therefore, the only recollection of one of the earliest "famous flights" of the Army Air Corps. It is to his credit that he preserved some portion of the Alaskan Flight in writing. His diary gives a personal account of a trip that enhanced the reputation of the Air Corps and created a bond between Arnold and Grow that would prove invaluable to the future establishment of a separate Air Force Medical Service.

George M. Watson Jr., Ph.D., is the chief historian, Office of the Air Force Surgeon General, Bolling AFB, D.C.

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Fairbanks Daily News-Miner

FARTHEST NORTH DAILY NEWSPAPER IN THE WORLD — MEMBER OF THE ASSOCIATED PRESS

VOLUME XXX. FAIRBANKS, ALASKA, TUESDAY, JULY 24, 1934. PRICE TEN CENTS

ARMY BOMBERS ARRIVE IN FAIRBANKS

Dillinger's Life Bartered Away By Woman

AVARICE AND LOVE SPELL BANDIT'S END

SEES MANY RADICALS

STRIKERS ON DOCKS TO END VOTETONIGHT

TO ENACT SHAKESPEAREAN ROLES

PLANES WILL BASE HERE THREE WEEKS

After flying more than 4,000 miles, the 10 bombers landed in Fairbanks, Alaska, on July 24, 1934. Their arrival was greatly heralded and even given precedence in the local newspaper over the shooting of the notorious John Dillinger.

Featuring

March AFB

Col. Joe E. Burton, MC
Col. John R. Sheehan, MSC

March AFB, located just east of Riverside and south of Moreno Valley, Calif., is the oldest Air Force base on the West Coast. The vicinity, also known as California's "Inland Empire," is vibrant with a diverse array of social, cultural, educational and recreational activities, and March AFB thrives here, making its own valuable contributions to a fast-growing region.

A Description of the Area

Cahuilla and Serrano Indian tribes inhabited the Riverside area long before the Spanish discovered it in 1774 during an expedition led by Juan de Bautista. Spanish and Mexican settlers arrived soon after to establish ranchos, missions and presidios and to begin assimilating the native population.

Known for its "seasonless" weather—sunshine almost 365 days a year—the Riverside community offers many outdoor recreational activities such as hiking, swimming, boating and horseback riding. Within a two-hour drive, anyone looking for fun can visit such renowned places as Disneyland, the San Diego Zoo and Sea World, Knotts Berry Farm, Magic Mountain and Universal Studios. And of course, choices abound for the sports enthusiast with the Los Angeles Rams, Raiders, Kings, Lakers and Dodgers residing nearby along with a myriad of college teams.

Educational opportunities and industrial success also make the Riverside area an attractive place to live. The University of California and Loma Linda University have Riverside campuses and, along with the California Baptist College and Riverside Community College, offer the best education in medicine, agriculture, arts and many other disciplines.

Although industry overtook agriculture in economic importance in the last few decades, citrus was the first major industry in Riverside and continues to make the area famous for its navel oranges and other delicious fruit. Today Riverside houses Rohr Corporation's aircraft engines, the Pepsi Corporation and Bourns, which manufactures instruments for guiding rockets and control machinery. As one of the premier Strategic Air Command (SAC) bases contributing to national defense, March AFB also plays a significant role in the local economy.

Capt. (Dr.) Jay S. Taylor (right) and Ms. Julie Smith (left) provide dental services at the 22nd Strategic Hospital, March AFB, Calif.

The Development of March AFB

The beautiful, 8,000-acre site of March AFB was originally called Alessandro Aviation Field. Over 73 years ago, the Riverside Chamber of Commerce lobbied successfully for a Wing Cavalry Post on the outskirts of their city, and the field was officially opened on March 1, 1918. The field was renamed in April, 1918 in honor of Lt. Peyton C. March Jr., who had died the previous month in an aircraft accident in Texas. March's father, Gen. Peyton C. March Sr., was the Army chief of staff during World War I.

Over the years, March AFB has played many different roles. It was used initially to train World War I "Jenny" pilots. Many well-known aviation leaders trained or served at March AFB, including Gen. Henry "Hap" Arnold, Gen. Carl "Tooey" Spaatz, Gen. Curtis LeMay and Lt. Gen. Ira Eaker. Following

World War I, the base was closed for approximately four years and reactivated in 1927 as a primary flying school, due in part to the request of Riverside citizens.

In 1938, March Field became the central base for West Coast bombing and gunnery training. Troops practiced bombing and gunnery at Muroc Dry Lake, now Edwards AFB, Calif., but then a part of March Field. Early in 1940, National Guard units from California and Illinois came for training in antiaircraft protection, doubling March's personnel strength to almost 4,000 officers and enlisted men.

Following World War II, March AFB retained its role as an operational fighter base until SAC took control in 1949. The 22nd Wing came to the base in May 1949 and began to make its mark. The 22nd was a "super" wing from 1966-1971, with two bombardment and two tanker squadrons. The base played a great role in the Southeast Asia conflict in the 1960s and early 1970s, serving as a staging area for bomber and tanker aircraft enroute to the Pacific.

Upon retiring their B-52 bombers in October 1982, the 22nd was redesignated as an air refueling wing. They accepted delivery of the wide-bodied KC-10A Extender, and the base entered a new era. Almost a decade later, the KC-10s assigned to March AFB were primary contributors to the success of Operation Desert Shield/Storm. The planes made broad projection of air power possible through their ability to refuel almost any aircraft in the DOD inventory and through their dual-capacity flexibility as transport planes. March AFB continues fulfilling its SAC refueling mission today, providing air refueling and cargo movement worldwide.

CAT scans, such as the one being performed above by Sgt. Wesley Wingo (left) and Lt. Col. (Dr.) Anna Pandula (right), are an example of March's high-tech patient care.

The Growth of Medical Care

The story of the 22nd Strategic Hospital at March AFB is richly intertwined with the history of air power and the Air Force. One of the key tenets making the Air Force Medical Service one of the finest health care systems in the world is its close relationship with its ultimate customer, the Air Force line. Health care at March AFB has grown and changed over the years, but has never strayed from that tenet—the patient comes first.

Built in 1918, the first base medical facility, a one-story wooden structure, had fewer than 30 beds for inpatient care and an operating room. This early building and staff served March until 1931. By that time, the nearly 2,000 people on base received care in a new, two-story masonry hospital located on the south side of the parade grounds. The "parade ground" hospital increased its capacity from 30 to 100 beds by 1965 and today is a base headquarters support complex.

World War II placed an additional burden on medical care. As a result, a temporary building was erected in 1942 at the corner of Riverside and Meyer streets. This structure had 532 beds with an expansion capacity of 704. Soon, however, the aging wooden cantonment buildings, groups of buildings connected only by covered walkways, became unsuitable for providing medical care. With the help of community leaders, construction of March's present hospital was approved.

The new hospital was built in 1964 as a model medical facility for its day. It was praised and pointed to with pride as one of the finest hospitals in the area. This 200-bed, five-story complex was built at a cost of $5.3 million. In 1976, a $5.5 million expansion housed clinics for OB/GYN, pediatrics, ear/nose/throat, general therapy, medicine, outpatient records, pharmacy and surgery. A new dental building with 24 dental treatment rooms and a laboratory was added in 1986. Now a $4 million seismic upgrade is near completion. Today, the 150,000 active duty, family members, retirees and numerous sister service beneficiaries receive professional, quality care from the 22nd Medical Group.

Staff and Services at March's Hospital

The 22nd Medical Group at March, made up of family physicians, pediatricians and general internists,

offers comprehensive primary care to beneficiaries of all services. An after-hours clinic manned by civilian primary care providers eliminates the need for a medical officer-of-the-day and greatly improves patient access to emergency services with minimal waiting time. A satellite PRIMUS Clinic located 12 miles north of the base offers additional acute care.

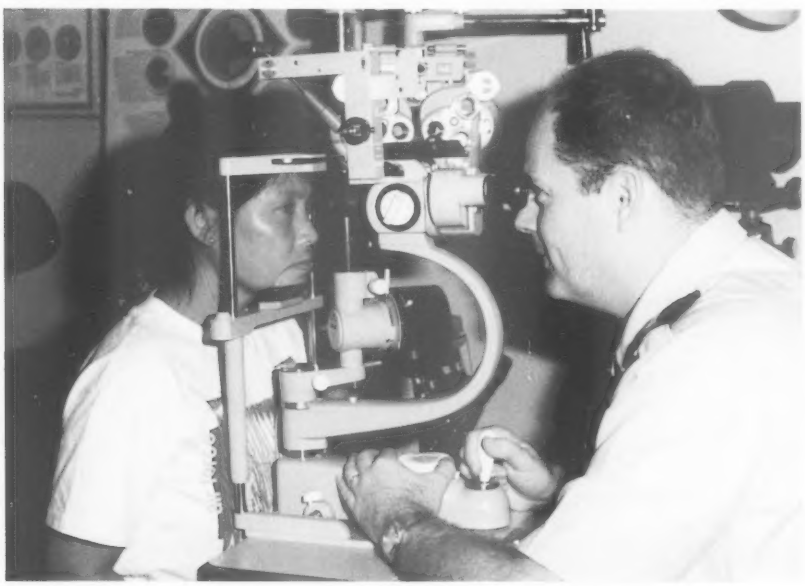
Under a new program called the CHAMPUS Reform Initiative (CRI) the team at the 22nd Strategic Hospital can offer services that are not available at other facilities. Through resource sharing agreements with civilian providers, March has gained numerous personnel, including physicians, nurse anesthetists, pharmacy and laboratory technicians, an entire inpatient unit for adolescent mental health, and more. Resource sharing has even helped March add a portable vascular lab, laparoscopic cholescystectomy equipment and an ultrasound unit. Because of savings in CHAMPUS costs through Partners National Health Plans, the CRI contractor of Southern California, these valuable additions have not burdened the 22nd Medical Group financially.

As the largest Air Force medical facility in Southern California, the 22nd Strategic Hospital has established traveling consultants in ear/nose/throat and orthopedics. Every six to eight weeks, physicians go to George, Fort Irwin, Edwards and Norton to see patients in the clinics and to perform uncomplicated outpatient procedures. Seeing 20 to 30 patients at those locations during the visits saves temporary duty travel money and eases patient inconvenience at the smaller bases. This program also gives the staff additional continuing medical education opportunities and promotes face-to-face contact with referral physicians.

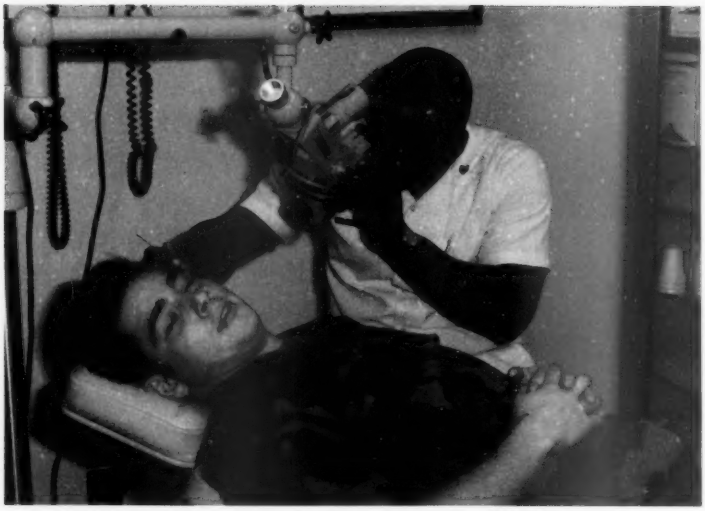
March's surgeons use the newest technique, laparoscopic cholescystectomy, for removing a diseased gallbladder.

Keeping up with the latest in technology, March began laparoscopic cholescystectomy services on Oct. 9, 1991. This state-of-the-art procedure is made possible by the joint efforts of Fort Ord Army Hospital, which provided the training for the general surgeons; Partners National Health Plan, which provided the equipment; and the surgery and nursing staffs at the 22nd Medical Group. March also now has in-house endoscopy capability. And thanks to a dedicated surgical staff and highly qualified nursing/technician assistance, the group will shortly become the SAC teaching center for endoscopy.

On Oct. 1, 1991, the Air Force's first adolescent mental health unit was opened at March. This triage



Capt. (Dr.) John E. Jackson Jr. conducts biomicroscopy with state-of-the-art equipment.



Sgt. Tony Gibson, NCO in charge of March's opthalmology department, gives a patient a routine ear cleaning.

unit will reduce CHAMPUS costs by hospitalizing youths for seven to 10 days for intense diagnostic evaluation to determine the level of care they need. Patients requiring further hospitalization will be referred to a contracted long-term facility, and the remainder will be followed in outpatient clinics. This unit will eliminate many civilian hospitalizations that extend for the CHAMPUS mental health limit of 60 days.

These are just a few of the tremendous services that March hospital offers its customers. March's comprehensive, quality health care program leaves no one out and is committed to giving first-rate attention to all needs.

Conclusion

Basking in the sunlight of California's "Inland Empire," the 22nd Strategic Hospital creates an enticing picture. With its up-to-date technology, dedicated professionals and terrific geographical location, the hospital offers many excellent opportunities for Air Force Medical Service members who have the good fortune to be assigned here.

Col. Joe E. Burton is the commander of the 22nd Strategic Hospital, March AFB, Calif., and Col. John R. Sheehan is the hospital administrator.

Surgeon General's Office Welcomes New Corps Chief

Col. Sue E. Turner, the new chief, Air Force Nurse Corps, pinned on the rank of Brigadier General on Dec. 20, 1991.

Coping with Perinatal Loss

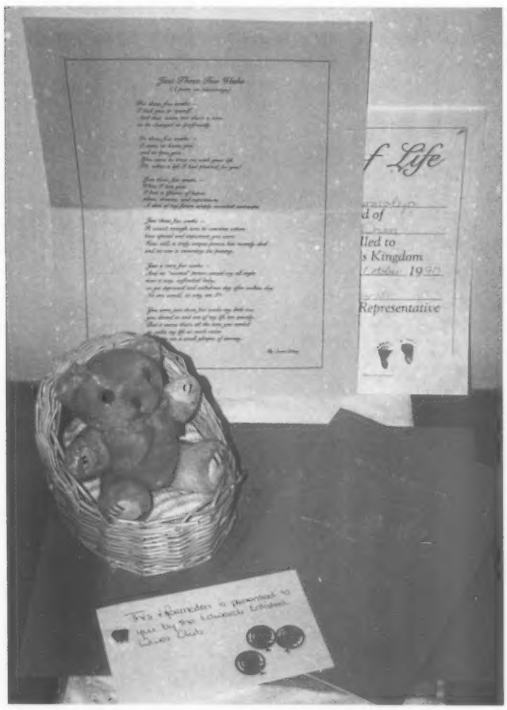
Program at Edwards Helps Families Heal

Capt. Kathy Jo Keever, NC

For most families who enter the hospital obstetrics unit, the outcome is a celebration of new life; a baby to feed, change, hold and love moves into their lives and hearts. For others, however, the family's life and future are greatly altered upon an often hasty arrival to the emergency room, clinic or obstetrical unit. Their dreams are dashed by the stark words, "We don't hear a heartbeat."

Shattered Dreams and Grief

Each year, more than one-half million dreams are shattered. Out of 3.3 million babies born annually, some 30,000 are stillborn. Miscarriage occurs in 15-20 percent of pregnancies and ectopic pregnancy makes up 1 percent (1). Regardless of the means of loss, parents experience real, and often overwhelming, grief.



The perinatal loss program at the AFSC Hospital Edwards provides special information packets for families experiencing miscarriage.

These losses are usually unexpected and sudden, and gradual acceptance of reality is often made difficult because societal traditions surrounding death, such as formal visitations, family gatherings and funerals, are not made available to families as an outlet for sorrow. The protective and nurturing care given by families and friends is unavailable, and "grief is dammed up in a reservoir with no flood gates to open" (2).

Understanding the Perinatal Loss Program

The AFSC Hospital Edwards, Edwards AFB, Calif., recognized the need to offer channels of release to families dealing with a loss. We realized the importance of continuing and compassionate care in helping these families experience the grieving process, and we took action to make sure that such care was not deterred for any reason. Over the past three years, with staff involvement, guidance from bereaved parents and financial support from numerous individuals and organizations, a comprehensive perinatal loss program has evolved that provides individualized care for bereaved families in the Edwards community.

We began our efforts after hearing concerns voiced by a patient in the obstetrics clinic regarding the lack of attentive care she perceived during the loss of her daughter. In the course of evaluating the problem, we explored our existing operating instructions (O.I.s) for perinatal loss and ultimately expanded them.

Our O.I.s play an integral part in all care that our patients receive, and the instructions need to be especially detailed for care given at a time when emotions are high. Our expanded O.I. inspired the creation of a comprehensive checklist that provides explicit guidelines for standardized care and also forms a basis for other operating instructions regarding care in the clinics, emergency room, inpatient surgery and the laboratory.

Nursing-care plans, specific to perinatal loss intervention, grief and discharge planning, were also devised to maintain continuity of care from shift to

shift and unit to unit. A Perinatal Loss Coordinator was designated to coordinate purchases and stock levels of supplies and keep abreast of current trends in new materials available for perinatal loss support.

Dealing with Miscarriage

Many of our families experiencing miscarriage are cared for in the clinics or emergency room or are admitted for an overnight stay in the inpatient surgery unit. We needed to find an effective way to reach these families, to give them basic information and open an avenue for contact at a later date if they desire it.

To do this, we developed a special miscarriage packet based on recommendations from bereaved parents and with financial assistance from our Enlisted Wives Club (EWC). This packet helps families understand miscarriage. Included is a booklet that defines miscarriage and explains why a miscarriage may occur and what a family might experience physically and emotionally during and after their loss. Other contents are a poem about the many emotions surrounding miscarriage, a thoughtful card and baby footprint pin from the EWC, and a bibliography of books available for additional reading about perinatal loss and grief.

We supplement the packets with additional information based on specific situations and needs. The extra material comes from a perinatal loss ready reference that we have established. The ready reference is located in our nursery and is a collection of articles, poems and guidelines for a variety of topics including types of perinatal loss; marriage and grief; sibling grief; and grandparent, family and community involvement. The ready reference also contains copies of our perinatal loss checklist and a bibliography for our lending library.

The Lending Library

Our lending library meets a real need for information and reassurance during grief. Located on the obstetrical unit, the library is composed of books, audio and video cassettes, pamphlets, prose and poetry. The literature covers the subjects of ectopic pregnancy, miscarriage, stillbirth, newborn death, the marriage relationship during loss, sibling involvement, memorial/funeral options and grief and the grieving process.

The material in our library has all been donated over the past three years by either bereaved parents, the EWC, the Officer's Wives Club (OWC) or staff members. Items may be checked out for use at home, and staff members are available to assist with finding specific topics or to provide counseling as required.

Photography Services

Another service that we developed to help the family establish memories and experience the grieving process is photography. We tell parents who are

Individual keepsakes help families go through the bonding and letting-go process of grief after neonatal loss or stillbirth.

Materials in the obstetrical unit's lending library give additional information and support to families during the difficult times of perinatal loss.

The Perinatal Loss Coordinator at Edwards, 1st Lt. Laura J. Bloxsom, holds one of the wicker craft bassinets used with photos.

experiencing miscarriage, stillbirth or neonatal death that it is our policy to photograph their baby, and we have several different ways to provide pictures depending on the needs of the families.

Our staff purchased a Polaroid camera that we keep available for the perinatal loss program and for photographs of sick and transferred babies. The OWC provides film for this camera on an annual basis. Also, we use a 35 millimeter camera or the family's camera to provide negatives. The parents may take the film home with them. We can keep the instant photos on file indefinitely, and we maintain some duplicates in case the originals are ever lost or destroyed. We do, however, advise the family to have a negative made from their Polaroid photos in case the photo fades over time (3).

We also provide the option for nursery photos through the First Foto company. This choice is particularly useful with stillbirth and neonatal deaths but may be an option for some miscarriages. When the family completes the appropriate forms, they can have a package of photos sent directly to them free of charge, or they have the option not to accept shipment of the photos for up to three years. The company keeps the negatives on file until then.

We have a collection of small wicker craft bassinets to use with photos of our tiny infants. Stocking caps or lace handkerchiefs are used to line the baskets and can also substitute as blankets or gowns in these photos. We encourage the family to personalize the photos with small stuffed animals and toys. These important pictures give the family a tangible, visual connection with their lost child. Many parents like to share these pictures with their friends and relatives (4).

Responding to Stillbirth and Neonatal Loss

When an infant is lost around the 20th week of gestation, more keepsakes can be saved for the family. We are able to give the family their baby's identiband, kindercap and blanket. Keeping these items sealed in a small plastic bag preserves any smells associated with the baby and uses another of the senses in the bonding and letting-go process of grief. Also, care involves mortuary affairs and burial arrangements. Having a funeral or memorial service provides an opportunity for the family to say goodbye.

We support these families by providing them with a neonatal loss packet, which includes three booklets about newborn death and parental grief, our bibliography for the lending library and information about funeral/memorial planning. The packet also contains information about incongruent marital grief, sibling and grandparent grief and the physical changes both parents will experience. We hope that this information will enable the family to begin their journey through the necessary, normal grieving process (5).

To help establish the identity of the child, giving the family a "someone" to grieve for, we obtain footprints and handprints and put them on a certificate of life along with the baby's name and birth/death date and the parents' names. We tape a lock of the baby's hair on the certificate to complete this unique gift for the parents. We keep a duplicate of the certificate on file for the family. The parents are offered the options of holding, bathing and dressing their infant. Clergy is always notified and a blessing offered if the family desires one.

After the family feels that they have spent sufficient time with their baby, we keep the baby on the unit until the parents leave the hospital, or for at least 24 hours, in case the parents, grandparents or siblings choose to see the baby again. Using a warmed blanket when holding the baby helps comfort the family.

The staff obtains follow-up information and makes telephone calls at recommended intervals for up to one year after the loss. The Perinatal Loss Coordinator (PLC) ensures that the calls are made by assigned staff. The PLC also provides emotional support to the staff, encouraging them and helping them to be consistent in their care.

Care for the Care Giver

Staff members are encouraged to seek counseling as needed for their own well-being. Verbalizing their concerns and feelings after working with a family's loss aids them in their future work with bereaved families. Counseling can give them ideas about handling their own grief process and bringing closure to the loss, perhaps by attending the memorial or funeral service, or sending a note or flowers to the family. The PLC and other staff members are encouraged to become certified in perinatal loss counseling to build their knowledge base and help alleviate some overwhelming feelings of failure that they may experience.

Grateful Families

We know that our program is working because families have responded positively. For example, numerous donations have been made to our lending library by bereaved families. Also, some members of the EWC and OWC have received care through our program, or know someone else who has, and they continue to praise and fund the program. The base Family Support Center expresses an open desire to continue their involvement in our program by sponsoring community seminars on perinatal loss and providing follow-up counseling for our families as necessary.

Our hope is for every family to leave our hospital happy and healthy. By helping them experience the normal grieving process and giving them the security that they are not alone in their loss, we enable the family to move through grief with a renewed outlook for the future.

Note: You may address inquiries for copies of checklists, care plans, O.I.s, a list of National Organizations for Perinatal Loss Support, or any additional information to: PLC 1st Lt. Laura J. Bloxsom, Unit II SGNO, AFSC Hospital Edwards, Edwards AFB, Calif. 93523.

At the time this article was written, Capt. Kathy Jo Keever was an obstetrical staff nurse at the AFSC Hospital Edwards, Edwards AFB, Calif. She is currently in the AFIT Master's Midwifery Program at Georgetown University and the Malcolm Grow USAF Medical Center, Andrews AFB, Md.

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Information for Authors

The focus of the *USAF Medical Service Digest* is on the people, programs and activities of the Air Force Medical Service. All members of the Medical Service are encouraged to submit interesting, informative articles that would appeal to a broad spectrum of medical officers, enlisted members and civilian employees.

Some Tips for Publication

Articles are selected for publication after review and approval by the editor and the *USAF Medical Service Digest* editorial advisory board. Members of the board are listed on page two of all *Digest* issues and are available, along with the editor, to discuss story ideas at any time.

Some patterns have emerged from recent decisions of the editor and board:

Focus on Air Force people, programs and activities. Articles that paraphrase a regulation, summarize a directive, restate a policy letter or delineate the steps in a process (you should do this, you must do that) are almost always rejected. On the other hand, articles that illustrate how medical people have accomplished a mission, successfully applied a process, met a challenge or responded to a crisis are always in demand. "Good news" stories are welcome.

Strive for broad readership. The Medical Service is made up of many educated, energetic, intelligent people, and the *Digest* needs to reach them all. Avoid writing articles that only your professional peers would understand. It is possible to make an otherwise narrowly focused topic interesting and applicable to a broad audience by carefully choosing a story angle and tone.

Use simple English and appropriate style. Overuse of acronyms, technical jargon and report-style words has doomed many articles to rejection. A good rule of thumb is to strive for content a high school student could understand. Write in conversational style. Active voice is always better than passive, and strong action verbs always outshine weak "being" verbs.

Submit photographs. A picture is indeed "worth a thousand words." Use action pictures, pictures of people, to grab your readers' attention and to emphasize your topic. Good pictures or line art, vs. diagrams, graphs and statistical charts, will draw a reader into your story.

Timeliness counts. Except for historical features, the editor and editorial advisory board always select topics of current interest over ones that are stale. Keep in mind that the *Digest*'s lead time (the time between when an article is received and the earliest it can be seen in print, i.e., the time necessary

for the publication process) is approximately three months. Plan your articles to keep them timely.

Avoid duplication. A quick review of recent issues of the *Digest* can help in this regard. Unless you have a totally new slant, topics published within the past year are poor candidates for publication.

Be factual. The author is responsible for ensuring that all material is complete, accurate and current. Articles with more opinion than fact (editorials) are almost always rejected.

Prepare for some editing. Almost all submissions are edited before publication. Some changes are made to keep within the space limitations of the *Digest,* while others are made simply to improve the final product. Accept editorial suggestions and changes positively.

Enjoy the writing experience. Having an article published in the *Digest* represents a significant professional and personal accomplishment. An enthusiastic, positive approach is evident to readers, members of the editorial advisory board and the editor.

Format for Submissions

In the interest of consistency, submission of articles for publication should meet the following specifications:

- Submit a typed original and two copies of double-spaced, 10-pitch (pica) text, with one-inch margin on all sides.
- Number each page except the first.
- Use subheadings whenever possible to organize the article and aid reader understanding.
- Number references consecutively in the order in which they are first mentioned in the text. Identify references in the text, tables and legends by Arabic numerals (in parentheses).
- For photographs, black and white glossies, either 5 inches by 7 inches or 8 inches by 10 inches work best. Please identify all people in pictures and write a brief explanation of each picture. Send original, camera-ready illustrations, diagrams and drawings because copies do not always reproduce well.
- Include name, rank, address, DSN number and duty title of all authors. If there is more than one author, please indicate if one is the primary author—the primary author will be listed first on the byline.

References

Use the style of the examples below that are based on the formats used by the U.S. National Library of Medicine in *Index Medicus*. Titles of journals are abbreviated according to the *Index Medicus* style.

Journals

1. Standard Journal Article (List all authors when six or less; when seven or more, use only the first three and add et al.)
You CH, Lee KY, Chey RY, Menguy R. Electrogastrographic study of patients with unexplained nausea, bloating and vomiting. Gastroenterology 1980; 79:311-4.
2. Corporate author
The Royal Marsden Hospital Bone-Marrow Transplantation Team. Failure of synergetic bone-marrow graft without preconditioning in post-hepatitis marrow aplasia. Lancet 1977; 2:242-4.
3. No Author Given
Anonymous. Coffee drinking and cancer of the pancreas [Editorial]. Br Med J 1981;283:628.

Books

4. Personal Author(s)
Robinson DH. The dangerous sky: a history of aviation medicine. Seattle: University of Washington Press, 1973:126.
5. Editor, Compiler, Chairman as Author
Daussett J, Colombani J, eds. Histocompatibility testing 1972. Copenhagen: Munksgaard, 1973:12-8.

Other Articles

6. Newspaper Article
Murphy C. 26 days in Kuwait: chaos, fear and tears. Washington Post Aug 29, 1990 A1 (col1).
7. Magazine Article
Budish AD. Avoiding the Medicaid trap: How to protect yourself from the staggering costs of nursing home care. The Retired Officer Magazine 1990 Sep, Vol XLVI, No 9:37-39.

Clearance Procedure

All articles require clearance before they can be published. Send your original and two copies to the *USAF Medical Service Digest* through the following official channels: supervisor, facility/unit commander, base public affairs office, MAJCOM public affairs office and MAJCOM surgeon. The **fully cleared article** is then mailed to:

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Other Questions?

The *Digest* editor and members of the editorial advisory board can help you with story ideas. In addition, the editor will be glad to answer any questions relating to the policies and procedures of the *Digest*. Please feel free to contact them at any time.

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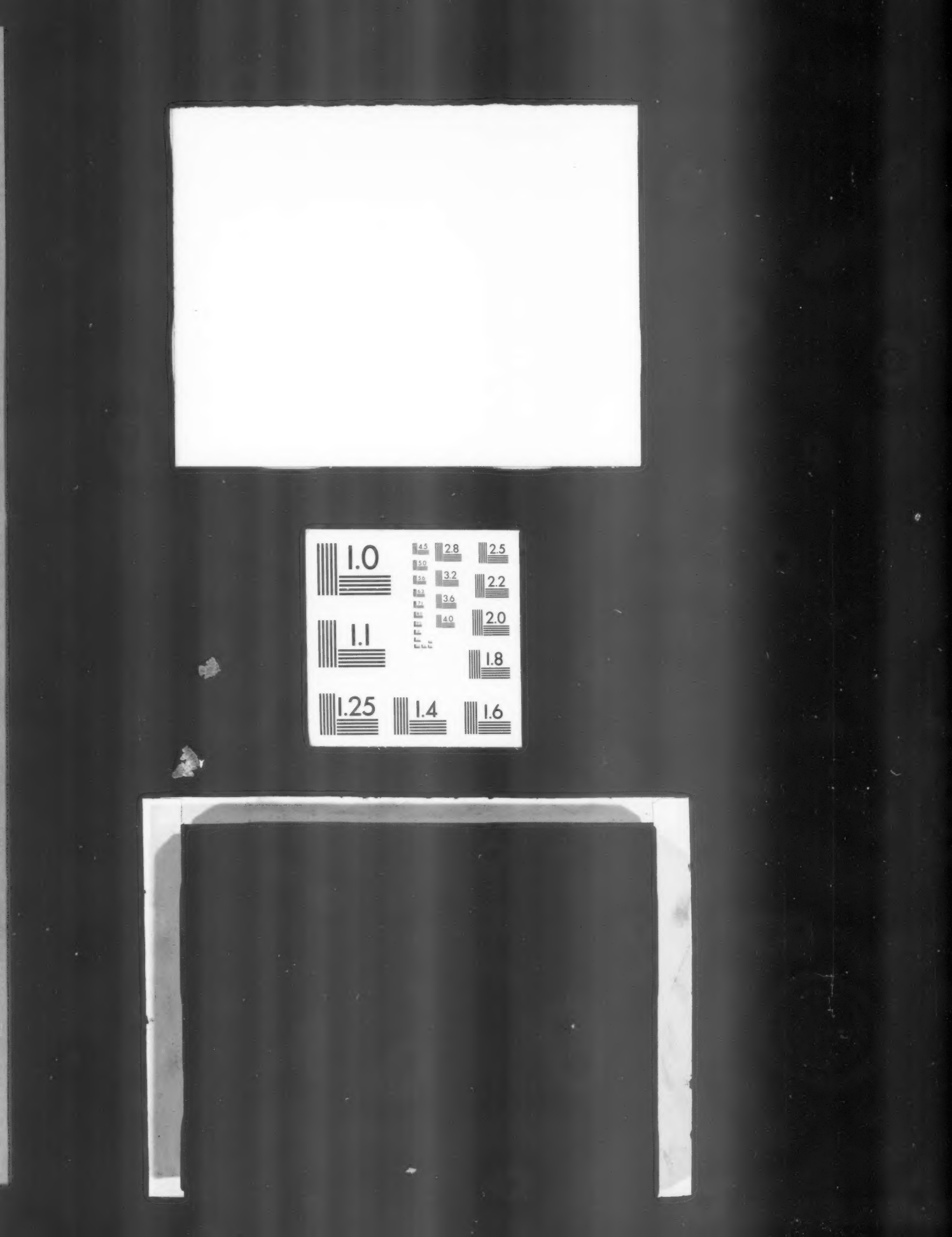
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